INDIVIDUAL HEALTH RATE FILING
HealthChoice and HealthChoice Standard & Basic

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Rule Chapter 940 Requirements

Carrier Information

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Submitted By

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Actuary
207 822-8949

SIGNATURE _____

Scope and Purpose of Filing

This memorandum is provided to support the proposed rate revisions for the individual HealthChoice (including Standard and Basic) products. It is intended to demonstrate compliance with 24-A M.R.S.A. §2736-C and any other applicable statutes and regulations. It is not intended for use for any other purpose.

This rate revision is being filed because claim costs associated with the benefits offered have increased and are expected to continue increasing and the rates for these products, if not increased, are and would continue to be inadequate.

Description of Benefits

HealthChoice is an individual PPO product with deductibles ranging from $150 – $15,000. For deductibles of $150 – $2,000 and $4,000, coinsurance applies up to an annual out-of-pocket maximum. A preventive care and supplemental accident amendment is available with the deductible options of $2,250, $5,000, $10,000, and $15,000. An additional optional amendment may be elected to cover listed mental illnesses at the benefit level provided for medical treatment for physical illnesses.

HealthChoice Standard & Basic are the statutory individual products that must be offered by any carrier that offers individual PPO products. Deductibles of $250, $500, $1,000 and $1,500 are available for each product consistent with Rule Chapter 750 requirements. An optional amendment may be elected to cover listed mental illnesses at the benefit level provided for medical treatment for physical illnesses.

In Force Business

As of June 2007, HealthChoice individual products in force enrollment included 13,502 contracts with an annualized premium of approximately $63,800,000 based on current rates.

Proposed Effective Date

These proposed rates are intended to become effective on January 1, 2008. The analysis and loss ratio calculations in this filing contemplate that the proposed rate revision will be implemented for all policies with the applicable premium payment for January 2008. In order to implement revised rates coincident with the January 2008 effective date, Anthem BCBS requests that the Bureau issue its Decision and Order on this filing no later than November 4, 2007. Delay in the implementation of the proposed increase would have an impact on the increases needed to ensure revenue is adequate to cover all underlying costs as set forth herein. Accordingly, if the Bureau determines that the Decision and Order will not be issued by November 4, 2007, Anthem BCBS requests that the Bureau advise Anthem BCBS as soon as possible so that the filing may be amended to contemplate a later implementation date.

Morbidity Assumed

Actual claim experience for the individual HealthChoice products of Anthem BCBS for the period May 1, 2006 through April 30, 2007, paid through June 30, 2007, and completed was utilized for development of the proposed rates. This experience is assumed to be 100% credible.

Mortality Assumed

Not applicable.

Issue Age Range

There is no limitation on issue age. However, new policies are issued to subscribers age 65 and over only if they are not eligible for Medicare Part A without paying a premium.

Premiums are on an attained age basis.

Average Annual Premium

In this filing, there are two blocks for rating purposes: HealthChoice Non-Mandated Options and HealthChoice Mandated Options.

	Non-Mandated	Mandated
Before rate revision:	$4,635	$11,736
After rate revision:	$5,511	$12,968
June, 2007 contracts:	13,330	172

Largest Premium Increase

The largest premium increase for the Non-Mandated Options is 22.6% for the $5,000 deductible option in all age bands for the one adult, two adults, and one or more children contracts. For HealthChoice Mandated Standard and Basic, the largest premium increase is 10.7% for both the Standard and Basic options with $1,500 deductible/$1,000 coinsurance limit in all age bands for the one adult, two adults, and one or more children contracts. These increases reflect changes in the community rate for the age band only. Additionally, any subscriber entering a new age band will incur an additional increase of:
(1) 3.1%, for those moving into the 30 to 39 from the under 30 age band, or
(2) 21.2% for those moving into the 40 to 44 from the 30 to 39 age band, or
(3) 7.5% for those moving into the 45 to 54 from the 40 to 44 age band, or
(4) 11.6% for those moving into the 55 to 64 from the 45 to 54 age band

Number of Policyholders

As of June 2007 there are 13,052 policyholders who will be affected by the rate revision.

Medical Trend Assumptions

The medical trend assumption is 15.2% applicable to all claims.

Maine Experience on the Form (Past and Future Anticipated)

Please refer to Exhibit III for the following experience information:

(1) Year
(2) Collected premium
(3) Earned premium
(4) Paid claims
(5) Paid loss ratio
(6) Change in claim liability and reserve
(7) Incurred claims
(8) Incurred loss ratio
(9) Expected incurred claims
(10) Actual-to-expected claims

National Experience

Not applicable.

History of Average Rate Adjustments

July 1992	9.4%	
July 1993	14.0%	
June 1995	15.3%	
September 1996	17.0%	
October 1997	6.3%	
January 1999	20.4%	
November 1999	15.7%	
January 2001	23.5%	
February 2002	12.7%	
January 2003	3.4%	
January 2004	0.0%	
March 2005	14.5%	
March 2006	16.3%	
January 2007	16.7%	
July 2007	1.3%	(inclusion of savings offset payment)

Renewability Clause

Individual HealthChoice products are guaranteed renewable.

Loss Ratio

Rule Chapter 940, Section 7 and 24-A M.R.S.A. §2736-C refer to several loss ratio standards. The minimum loss ratio under any of these standards is 65%, which means that the loss ratios projected for these products must be at or above 65%.

Except in 1993, past actual loss ratios have been higher than 65%. The lifetime incurred loss ratio for individual HealthChoice is 82.5% through year-end 2006.

If the rates are increased as proposed in this filing, the estimated anticipated loss ratio for calendar year 2008 will be 87.4%.

Premium Classes

Contract type factors are as follows:

	current	proposed
One Adult	1.00	1.00
Two Adults	2.00	2.00
Two Adults/Child(ren)	2.65	2.53
One Adult/Child(ren)	1.65	1.57
Child(ren)	0.65	0.65

Age band factors are as follows:

	Current
Age less than 30	0.800
Age 30 to 39	0.825
Age 40 to 44	1.000
Age 45 to 54	1.075
Age 55 to 64	1.200
Age 65 and above	1.500

Rates for any contract types with two adults in different age bands are determined by the age band of the policyholder. In the event that the policyholder is in an older age band than the other adult dependent Anthem BCBS will endeavor to inform the policyholder of the opportunity to receive a lower premium by changing the policyholder to the dependent adult.

On the occasion when a subscriber changes age bands due to a birthday in the course of the calendar year the new rate for the higher age band will go into effect on January 1 of the following calendar year. In the event that an approved rate change is delayed beyond January 1 the new age band rate will take effect at the time of the application of the rate change.

Marketing Method

This product is typically marketed through direct mail and newspaper advertising. An in-house staff of account executives responds to telephone inquiries. Product information is available on the Anthem BCBS website. Every telephone directory in Maine lists an 800 number for Anthem BCBS. Appointed producers also sell individual products throughout the state.

Enrollment kits sent in response to any inquiry include information about all individual products sold by Anthem BCBS, including Standard and Basic HealthChoice, that potentially meet the needs specified in the inquiry.

Medical Underwriting

All Anthem BCBS individual products are offered on a guaranteed issue basis. No medical underwriting is done during the sales or acceptance/enrollment processes. Anthem BCBS determines which new members will have pre-existing condition ("PEC") restrictions applied to their coverage. If and when these members incur claims during the applicable period, the medical underwriting process is used to administer the PEC limitations, according to state statutes.

Notice to Policyholders

Notice of the proposed rate revision will be mailed on or about August 23, 2007. Written confirmation of the notice will be provided to the Bureau of Insurance when the notices have been sent. A draft letter is included with this filing.

Statement of Qualified Actuary

I have examined the assumptions and methods used in determining the claim assumptions and the premium rates for the HealthChoice, HealthChoice Standard and HealthChoice Basic rate filing. In my opinion, the claims and premium rates are calculated in accordance with accepted actuarial standards consistently applied and are reasonable in relation to the benefits provided. In my opinion, the proposed premium rates are neither excessive, inadequate, nor unfairly discriminatory.

The purpose of this filing is to demonstrate compliance with 24-A M.R.S.A. §2736, and any other applicable statutes. This rate filing is not intended to be used for other purposes.

_____ _____

William M. Whitmore, ASA, MAAA
Actuary
Anthem Blue Cross and Blue Shield

August 16, 2007

ACTUARY'S MEMORANDUM

This memorandum is filed in support of individual product premium rates proposed to be effective January 1, 2008.

Introduction

This memorandum describes the development of proposed premium rates for the individual HealthChoice products of Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield ("Anthem BCBS") effective January 1, 2008. The products affected are:

- HealthChoice
- HealthChoice Standard (Standard Plan A)
- HealthChoice Basic (Standard Plan B)

Summary of Filing Exhibits and Proposed Premium Increases

Exhibit I

Anthem BCBS in this filing has combined the experience for the Non-Mandated and Mandated Standard and Basic HealthChoice book of business for rating purposes due to the lack of credibility associated with the Mandated block.

The primary objective of Exhibit I is to project premium levels which will cover all costs and allow for what the Bureau has determined to be a reasonable amount for profit considering the risks of the Maine insurance market generally, and the HealthChoice membership specifically. Exhibit I shows the derivation of the required premium increase through the projection of claims forward to the future rating period, including projected administrative expenses, commissions, premium tax, pre-tax profit/risk charge, investment income, rebates related to pharmacy claims, the savings offset payment ("SOP"), and an adjustment for changes as the result of laws passed in the first session of the 123rd Maine Legislature.

Claim Base: As a claim base Anthem BCBS chose the twelve month period ending April 30, 2007 which was completed with two months of claim runout to account for claims incurred but not yet paid (Exhibit V provides the historical claim triangle on which the completion for claims incurred but not yet paid was based). Anthem BCBS also analyzed Exhibit I with a claim basis of a twelve month period ending May 31, 2007 with one month of claim runout. The period ending April 30, 2007 produced a lower premium increase so Anthem BCBS chose to utilize this period to create a lower level of premium increases. Anthem BCBS believes that both periods are credible and reasonable based on the variance in historical completion patterns for twelve months of incurred data.

Claim Trend: An annual claim trend of 15.2% has been applied to the twelve month claim base and trended forward for twenty months in order to estimate claims for the pricing period of twelve months ending December 31, 2008. Significant detail supporting the projected claim trend is included in the summary section for Exhibit VI.

Projected Enrollment: Enrollment in HealthChoice has been decreasing consistently since late 2005. Anthem BCBS has projected enrollment through the end of 2008 based on historical enrollment patterns

associated with past rate adjustments coupled with the premium increases proposed in this filing. Enrollment is projected in detail at the benefit level and then reviewed in the aggregate for reasonableness. Changes in the distribution of enrollment across benefit options results in adjustments to both claims and premium which are addressed in the summary section for Exhibit II.

Pharmacy Rebate Credit: Certain pharmacy claims incurred by HealthChoice members are eligible for and receive rebates from pharmaceutical manufacturers. All pharmacy rebates associated with claims incurred by HealthChoice members are credited as a reduction to claims in Exhibit I. Details of the pharmacy rebate calculation are presented in the summary section for Exhibit VIII.

Administrative Expenses: The proposed rates contained in this filing include administrative expense charges of $37.01 per contract per month ("PCPM"), or $20.91 on a per member per month ("PMPM") basis. The Wellpoint Hyperion System, a cost allocation system, has been used in order to determine the appropriate administrative costs associated with administering all functions related to HealthChoice. The cost allocation system allocates administrative expenses down to the product level. Each cost center within Anthem BCBS submits its budget along with a survey detailing what products the cost center supports and the function provided. Additionally, weighted membership and/or headcount are principally used in order to determine the percentage of each cost center's budget that will be allocated to a particular product

The value currently projected for 2007, $20.91, by the allocation system is approximately 7.6% lower than what is included in current HealthChoice rates. This reduction reflects Anthem BCBS's efforts to administer its business as efficiently as possible. Although there may be cost increases during 2008 that are unknown at this time, given the decrease in administrative expenses year over year, Anthem BCBS has determined not to include an inflation factor to determine the projected administrative expenses for 2008. In this way, the filing holds premiums at a level as low as possible to cover all associated costs.

Commissions: The proposed rates contained in this filing include a commission amount of $1.77 PCPM. Details supporting the commission amount are presented in the summary section for Exhibit XI.

Pre-Tax Targeted Profit and Risk Percentage: Anthem BCBS has consistently contended, with no disagreement from intervening parties or the Superintendent, that the rating of health insurance in general, particularly individual health insurance with high deductibles in a guaranteed issue and renewable environment, carries a high level of risk due to the potential for claim volatility and adverse selection. Due to the guaranteed issue and guaranteed renewable requirements, individuals have the ability to buy in and drop out of the pool at will, which also has the tendency to increase the risk that projections will not be achieved. As Anthem BCBS remains the only significant insurer in this market, HealthChoice has become a de facto individual high-risk pool for the State of Maine. The pool's experience is clearly deteriorating significantly and rapidly as evidenced in claim trends consistently in the mid to high teens.

In prior orders, the Superintendent determined that a 3% pre-tax margin for profit and risk for the HealthChoice products was sufficient. As illustrated by the significant losses for this product in 2005 and 2006, (approximately $3.0 million and $7.6 million respectively), a 3% pre-tax margin is inadequate to cover the risks associated with providing individual insurance in this market and still produce a reasonable rate of return. The $10.6 million in accumulated losses over the past two years demonstrates the validity of Anthem BCBS's concerns with the adequacy of the previously approved profit and risk margin. In this filing, Anthem BCBS has not embedded any component in the proposed rates to recover the multi-million dollar losses, but those losses are relevant when considering what level of margin is

necessary going forward to ensure that HealthChoice remains a commercially viable product for Anthem BCBS to offer in the State of Maine. Despite Anthem BCBS's consistent and valid contention that a pre-tax profit and risk charge of 5.0% is justified and arguably at the low end of reasonableness based on recent HealthChoice performance, an amount of 3% for a targeted pre-tax profit and risk component is included in this filing in order to hold the required level of premium increase as low as possible. The inclusion of the 3% level in this filing does not reflect a belief on Anthem BCBS's part that this is an adequate level based on the risks associated with this product and the market and regulatory environment in which it is sold.

Premium Tax: This filing assumes that premium tax of 2.0% will apply to HealthChoice premiums.

Investment Income Percentage: The proposed rates contained in this filing include an investment income credit in the amount of –0.54%. Details supporting the investment income amount are presented in the summary section for Exhibit VIII.

Savings Offset Payment: The proposed rates include the SOP of 1.85% as determined by the Dirigo Health Agency Board ("DHA Board") to be effective from July 1, 2007 through June 30, 2008. Details supporting the SOP amount included in the proposed rates are in the summary section for Exhibit VII. In the last two year's HealthChoice proceedings, the Superintendent determined that "Anthem has made best efforts to ensure recovery of the savings offset payment through negotiated reimbursement rates with health care providers that reflect the health care providers' savings as a result of Dirigo health care initiatives." (*See* INS-05-820, December 20, 2005 Decision and Order, §IV.D) Anthem BCBS continues to use those efforts to recover any available savings through negotiated reimbursement rates with health care providers. Anthem BCBS continues to aggressively pursue the lowest possible unit cost increases in all rate negotiations with hospitals. Our rate negotiations consistently result in rates of increase that are at or below the hospitals' board-approved rate increases. Hospital efforts to comply with past voluntary targets in the Dirigo legislation may have produced some moderation in hospital rate increases, which are then utilized to directly determine the underlying trend in premium rates. In the event that trends are more favorable due to the Dirigo legislation than they would otherwise be, it is reflected in the proposed rates through lower base claims. Additionally, anticipated unit cost trends reflecting any savings included in the aggregate measurable cost savings determination are reflected in the projected unit cost trends incorporated in this filing.

The DHA Board has not yet determined an SOP amount for paid claims effective July 1, 2008 through the end of the rating period. If the DHA Board makes an assessment effective July 1, 2008 that is below 1.85%, Anthem BCBS will request that the Superintendent approve of rates that reflect the reduced SOP. If the SOP amount effective July 1, 2008 is higher than 1.85%, however, Anthem BCBS would prefer to maintain the 1.85% SOP through the entire rating period to avoid a mid-year upward rate adjustment. Anthem BCBS recognizes that the Dirigo Health Agency determines how much to collect in the SOP and, accordingly, Anthem BCBS will make this proposal to the DHA. If the DHA disagrees with this approach, as authorized in the previous HealthChoice rate proceeding, Anthem BCBS is requesting that the filing be approved as is with the existing SOP, with a provision authorizing a compliance filing to include an adjustment if the assessment is modified at any point during the rating period. When notifying subscribers of the filed rate increases, Anthem BCBS will include an explanation that rates will be impacted if the SOP is modified during 2008.

Newly Mandated Benefits: There were a number of laws passed in the first session of the 123rd Maine Legislature that directly impact HealthChoice. Each law is summarized here along with a description of how it is addressed within this filing.

1. Public Law Chapter 153 (LD 101) *"An Act to Enhance Screening for Breast Cancer."*
This law revises the screening mammogram mandate to require that it include an additional radiological procedure when recommended by a provider because the results of the initial procedure are not definitive. This law applies to all policies, contracts and certificates executed, delivered, issued, continued or renewed on or after January 1, 2008.

Anthem BCBS already covers additional radiological procedures when recommended by the provider due to the initial procedure not producing definitive results. Therefore there is no anticipated impact on claim costs.

2. Public Law Chapter 452, (LD 1514) *"An Act to Require Health Insurance Coverage for Hearing Aids."*
This law requires coverage for hearing aids for children covered by individual and group policies. Coverage may be limited to $1,400 per hearing aid for each hearing-impaired ear every 36 months. This law takes effect as follows: for children from birth to age 5 who is covered under a policy or contract issued or renewed on or after January 1, 2008; children 6-13 years of age covered under a policy or contract issued or renewed on or after January 1, 2009; children 14-18 years of age covered under a policy or contract issued or renewed on or after January 1, 2010.

Anthem BCBS has chosen to implement this newly mandated benefit on January 1, 2008 for all ages through eighteen rather then phase it in over time. Anthem has used HealthChoice membership data and anticipated cost and utilization in order to determine the expected additional claim cost due to this new mandate. The calculation is shown in Exhibit VIII and the amount is added into the claim projection in Exhibit I.

3. Public Law Chapter 115 (LD 841) "*An Act to Extend Health Insurance Coverage for Dependent Children up to 25 Years of Age."*
This law requires individual and group health insurance policies to offer to continue coverage for dependent children up to 25 years of age at the option of the policyholders for individual policies and at the option of the contract holder for group policies. Dependent child is defined as a child of a person covered under a policy when that child is unmarried; has no dependent of his or her own; is a resident of the State or is enrolled as a full-time student; and is not covered under another policy or governmental program. This law applies to all policies, contracts and certificates executed, delivered, issued or renewed on or after September 20, 2007.

Anthem BCBS is requesting of the Superintendent that this newly mandated dependent coverage be implemented for all contracts. Within Exhibit XIII Anthem BCBS has presented its analysis of the potential impact of the newly covered dependents. It is necessary to consider a number of potential implications including but not limited to: newly covered dependents who will add no new premium (a dependent added to an existing family contract), newly covered dependents who will add new premium (a dependent added to an existing one adult or two adult contract), and the potential for adverse selection (subscribers more often adding dependents with health conditions than those that are healthy). Based on our analysis of the impact Anthem BCBS is proposing changes to the contract type factors for the two family contract types as presented in detail in Exhibit XIII.

Proposed Change in Pharmacy Benefits: Anthem BCBS has proposed to the Bureau of Insurance a change in pharmacy coverage for a class of drugs called proton pump inhibitors ("PPI"). PPIs are used to help reduce gastric-acid production and treat acid reflux symptoms. Several prescription medicines

are available in this class and numerous clinical studies have shown that all PPIs are clinically comparable in safety and efficacy but vary in cost. Anthem BCBS's proposal is to cover the lower cost prescription PPIs and not cover a number of the higher cost drugs. Anthem BCBS has included a claim reduction to reflect this proposed change.

Exhibit II

The distribution of enrollment across benefit options has changed over time with a shift toward higher member cost sharing levels. The impact of the shifting enrollment has lessened over time as the percentage of members in the higher deductible options has stabilized. However, enrollment projections still assume an increase in the average member cost sharing level and the impact of this shift on claims needs to be reflected in order to accurately project future claims.

The method for measuring the impact is the same as in past filings. Observed levels of claims are determined on a PCPM basis. Total average claim levels are then calculated using the current and estimated future enrollment distribution. The ratio of the future to the current average PCPM is calculated as the impact. The adjustment included in this filing is 0.926 for claims. In other words, it is expected that future enrollment shifts will reduce claims by 7.4%.

Exhibit III

In order to collect premium that will cover future costs and allow for a targeted profit and risk amount it is necessary to measure the impact of the increase on subscribers categorized by benefit option, age band, and contract type. Anthem BCBS is not proposing any change in age bands, but is proposing changes in contract type factors. As a result, premium increases will be consistent across age bands but different for contract types. However, due to the constraints of Rule 940 and the impact of benefit leveraging on carrier liability it is impossible to apply the same increase for all benefit options. Exhibit III presents the current and projected enrollment distribution by benefit option, age band, and contract type and the current and proposed premiums associated with this distribution that result in an aggregate future premium of $63,303,001 as determined in Exhibit I (the total amount in Exhibit III differs slightly from Exhibit I due to rounding).

Rates were determined for Mandated options by first applying a factor of 1.5 to the Non-Mandated $1,000 deductible option to set the Standard $1,000 deductible. This step is as recommended by the Superintendent in his Decision and Order for the 2006 HealthChoice proceeding and ultimately approved in the final Decision. In the next step, the remainder of the Non-Mandated rates are determined through compliance with Rule 940 rating restrictions.

As reflected in Exhibit III, the total average increase based on current enrollment is 18.6%.

Exhibit IV

In order to satisfy the component of Rule 940 that applies to allowable rate differences ("rates for different benefit plans that vary based on benefit differences may not exceed the maximum possible difference in benefits") it is necessary for the rate for the oldest age band and the greatest number of average dependents to first satisfy the requirements and then the younger ages and contracts with fewer average dependents will automatically be in compliance. Exhibit IV presents the proposed differences in premium between benefit differences and that these differences comply with Rule 940. Also included are utilization factors approved in the last two HealthChoice Decisions and Orders. The Superintendent approved a requested exception to Rule Chapter 940 within the Non-Mandated Options based on differences in utilization at various levels of cost sharing confirmed in analyses by Milliman, USA. *See*

Attachment D. Consistent with the Superintendent's determination, Anthem BCBS has applied the same utilization factors within pricing for the five non-mandated options with deductibles $150, $300, $500, $750, $1,000, and $2,250. Both the allowable benefit difference and the utilization factors are used in their entirety. Anthem BCBS has not implemented new utilization factors as these factors should change very slightly over time. As health care costs are increasing the impact on utilization patterns would be to increase the magnitude of expected differences between varying levels of benefits. Anthem BCBS will reevaluate on an annual basis the need to update these factors.

Exhibit V

Presented in Exhibit V are HealthChoice claims by incurred and paid month from December 2002 through June 2007. This is typically referred to as a "claim triangle" and represents payment patterns for a historical period.

Exhibit VI

Presented in Exhibit VI are historical and projected claim trends. The HealthChoice enrollment distribution across benefit options has changed over time. This change, coupled with the levels of cost sharing inherent in the HealthChoice benefits, has had noticeable impacts on the observed trends in benefit payments. Changes in the average level of cost sharing create a two-tiered impact on the trend in benefits paid. First, as the average level of cost sharing increases over time, this can create observed trends of average benefit payments per member that are lower than the underlying claim trends. Second, the impact of leveraging on the observed benefit payment trend can be masked by changes in the average level of cost sharing. Moreover, with inconsistent changes in average member cost sharing, the leveraging impact can have a significant effect on the trend in observed benefit payments. Due to these impacts on benefit paid trends Anthem BCBS also analyzes average "allowed amount"[1] costs per member per month by service types over the past few years in order to gain a better understanding of true underlying changes in provider payments and utilization of services and the trends associated with these changes. These costs are broken up into categories: hospital inpatient, hospital outpatient, physician, and prescription drugs. Also, within each category, changes in payments are broken down and reviewed for the impact of both the cost and utilization component of the change. As reflected in the Exhibit, benefit paid trend, which for some time was lower than the allowed amount trend, has now surpassed the allowed amount trend. This reflects the stagnation of the average member cost sharing and the impact of leveraging on the benefit paid trend.

Anthem BCBS conducts trend analysis and selection both retrospectively and prospectively. Observed claim data is reviewed on both an allowed and paid benefit basis by category: inpatient, outpatient, professional, and prescription drug. Information concerning known and anticipated changes to provider contracts and care management initiatives are considered for their potential impact on future claims. With this combination of historical and prospective information, trends are then selected for the categories noted previously. Each trend, and the composite trend, is reviewed for reasonableness based on observance of history and expectations for the future. As will be explained in more detail below, in several instances, Anthem BCBS proposes a trend factor that is lower than recent observed data. While Anthem BCBS believes this is reasonable, if recent trend observations do not moderate, the rates resulting from the proposed trend factors may be inadequate. HealthChoice has clearly become the coverage of last resort in Maine and acts as a de facto high risk pool without the benefit of any subsidization of premiums for policyholders with lower incomes.

[1] Allowed amount is the sum of Anthem BCBS and member liability.

Also, Anthem BCBS has presented an aggregate (not split out between categories) allowed amount trend after the removal of claims and members with claims exceeding $100,000. The trends resulting from the removal of the large claims proved to be more erratic than the trends including large claims. Anthem BCBS believes that the level of the overall claim trend is driven by a small minority of HealthChoice members incurring a disproportionate amount of the claims. Removal of these claims will not produce a clear and representative picture of HealthChoice claim trends.

Following is a description of the information considered in selecting the projected trends presented in Exhibit VI:

Leveraging

Anthem BCBS utilizes deductible leveraging factors included in the Milliman Health Cost Guidelines. These factors are intended to reflect the impact of deductibles on unit cost trends. Anthem BCBS uses the factors coupled with the unit cost trend within each category in order to calculate the leveraging factors. The factors are calculated as follows:

Illustrative Example:

A. Annual underlying trend:	5.0%
B. Deductible level:	$7,500
C. Trend leveraging factor:	1.38
D. Effective annual trend:	(0.05 x 1.38) = 0.069 or 6.9%
E. Leveraging factor:	1.069/1.050 = 1.018 or 1.8%

In order to determine a leveraging factor for the entire block Anthem BCBS has utilized the methodology as presented in Attachment A in the Decision and Order issued by the Superintendent in last year's HealthChoice proceeding. This methodology determines a leveraging factor for each deductible level and then weights these factors by the anticipated enrollment distribution. The calculation is presented in Exhibit VII and results in a leveraging factor of 1.23.

Mix of Services

Anthem BCBS analyzes historical unit cost increases in comparison to what was expected based on hospital contracts in order to estimate the impact of the change in the mix of services. Typically, the actual observed unit cost increases are higher than the expected unit cost increases, indicating the utilization of a higher cost mix of services, which would be expected in an aging pool that may also be deteriorating in overall average health. For the inpatient, outpatient, and professional settings, the actual observed unit cost trend from calendar year 2005 to 2006 is compared to the expected unit cost change for that period, and the calculated difference is the value used for the impact of the change in the mix of services. The factors are calculated as follows:

Illustrative Example:

A. Annual observed unit cost trend:	6.0%
B. Expected annual unit cost trend:	4.5%
C. Impact of change in mix:	1.06/1.045 = 1.014 or 1.4%

Inpatient

Based on data from provider contracting representatives and review of long term reimbursement contract provisions, the anticipated annual increase in average hospital unit cost for the projection period is 7.2%. This unit cost increase reflects any savings experienced by Anthem BCBS due to lower hospital unit price increases as the result of the impact of Dirigo Health. Anticipated changes in the mix of services is expected to add another 4.8% while leveraging is expected to add 2.6% resulting in a total unit cost trend of 15.2%. The 15.2% is slightly below the most recent observed benefit paid unit cost trend of 17.6% and within the range of reasonableness suggested by recently observed data. Inpatient unit cost trends tend to be the most dynamic due to the nature of the impact of large cases.

The measure of inpatient days per 1000 member months (days/1000) is used for analyzing observed inpatient utilization for HealthChoice. The trend in the change of days/1000 has varied over the observed period. An increase of 1.0% is projected for the rating period. This is below the annualized trend over the past two years. Due to the inconsistent nature of this trend this projection is reasonable although on the low side of a range of reasonable trends.

Combining the inpatient benefit cost and utilization trends: 1.152 x 1.010 = 1.164

Outpatient

Based on data from provider contracting representatives and review of long term reimbursement contract provisions, the anticipated annual increase in average hospital unit cost for the projection period is 5.6%. This unit cost increase reflects all anticipated provider costs, including any savings due to lower hospital unit price increases as the result of the impact of Dirigo Health. Anticipated changes in the mix of services is expected to add another 1.9% while leveraging is expected to add 1.7% resulting in a total unit cost trend of 9.4%. The 9.4% is slightly higher than observed trends but reasonable given contracting expectations and the impact of leveraging and mix.

The measure of outpatient services per 1000 member months (services/1000) is used for analyzing observed outpatient utilization for HealthChoice. Increases in outpatient utilization have been relatively steady over the past two years. An increase of 5.0% is projected for the rating period. This increase is slightly below recent observed values and significantly below the most recent observed point.

Combining the outpatient benefit cost and utilization trends: 1.094 x 1.050 = 1.149

Professional

Based on data from provider contracting leadership, the average fee increase for professionals during the rating period will be 2.0%. Anticipated changes in the mix of services is expected to add another 1.6% while leveraging is expected to add 0.8% resulting in a total unit cost trend of 4.4%. The 4.4% is slightly higher than the most recent observed benefit paid trends but well below trends observed in 2005 and 2006 and reasonable give contracting expectations combined with mix and leveraging.

The measure of professional services per 1000 member months (services/1000) is used for analyzing observed professional utilization for HealthChoice. Increases in the use of professional services were at a much lower rate in 2004, but started to accelerate in late 2005 and have continued into 2007. An increase of 10.5% is projected for the rating period. This increase is slightly below recent observed values.

Combining the professional benefit cost and utilization trends: 1.044 x 1.105 = 1.154

Prescription Drug

Projections of increases in the cost of prescription drugs are based on expectations provided by representatives of NextRx, the Pharmacy Benefit Manager for Anthem BCBS, coupled with observations of actual data.

As has been the case for many years, a number of items are expected to impact trend in 2007 and 2008 including: brand drugs becoming available in generic form, new specialty drugs, new brand drugs, slowing in the increase of generic drugs, and fewer drugs moving to over-the-counter availability. The total impact of these items on the prescription unit cost trend through the rating period is expected to result in a slight increase in 2007 followed by a more substantial increase in 2008. Coupled together, the expected annual increase in unit cost in the projected period is 6.3%. This projection incorporates an assumption for the change in the mix of drug usage. Factoring in the impact of leveraging, estimated at 1.4%, results in a total benefit cost trend of 7.8%. The choice of the 7.8% trend is considerably below observed benefit paid trends over the past year, which have ranged from 11% to 16%. The ratio of benefit paid to allowed amounts has increased over the past year, which might suggest that the methodology of leveraging determination may not apply as well to prescription drug claims as it does to other categories, due to the lower average cost and frequency of utilization of prescription drugs. When prescription drugs are subject to "copays", the impact of leveraging is much easier to determine, but when they are subject to a deductible along with the medical services, it is more difficult to measure. While a larger prescription drug trend is justified given recent observances, Anthem BCBS has made the decision to maintain consistency in our method of trend determination and maintain the trend as projected.

The measure of prescription drug scripts per 1000 member months (scripts/1000) is used for analyzing observed prescription drug utilization for HealthChoice. Increases in the use of prescriptions were relatively stable in 2005 through 2007 to date. An increase of 4.0% is projected for the rating period. This increase is slightly below recent observed values.

When weighted together, the inpatient, outpatient, professional, and prescription drug trends result in a combined trend of 15.2%. Based on our actuarial judgment and the preceding analysis, we have assumed an underlying average benefit paid claim trend of 15.2% to be used to project claim payments to the rating period. When compared to recently observed benefit paid trends the 15.2% is at the very low end of the range of recent observances.

Healthcare trends continue to exceed general inflation trends. Both inflation in the cost of services and increases in the utilization of services by members are contributing to the magnitude of the trends.

Exhibit VII

As mentioned previously, Exhibit VII presents the detailed calculation of an aggregate leveraging factor as presented in Attachment A in the Decision and Order issued by the Superintendent in the 2006 HealthChoice proceeding.

Exhibit VIII
Numerous components applicable to the proposed rates are included in Exhibit VIII.

First, Anthem BCBS has incorporated the same methodology as ordered by the Superintendent in a past HealthChoice proceeding, which results in an investment income credit of -0.54%. Investment income represents an interest rate of 4.91% based on the Dreyfus Money Market Fund 30-day rate for May 31, 2007, which is the same standard used in last year's filing.

Second, the calculation of the SOP component of the rates in presented. The DHA Board set the SOP at 1.85% of applicable claims (claims incurred by a Maine resident with a Maine provider). The percent of HealthChoice claims which are subject to the SOP is 75% in the recent observed period. Therefore when applied to all claims in Exhibit I the appropriate percentage is 1.39%.

Third, consistent with the past two year's HealthChoice filings, Anthem BCBS is crediting an estimate of rebates related to pharmacy claims anticipated in 2008. Also credited in this filing is an additional amount for calendar year 2006. At the time of last year's filing the rebates for 2006 were estimated, but have since been finalized with actual data. The 2006 pharmacy rebate amount is higher than was estimated, so an additional amount is included in this filing as a credit to claims.

Anthem BCBS developed the estimate for 2008 rebates by starting with the 2006 actual rebates and trending forward based on two primary assumptions: (1) pharmacy utilization is expected to increase by 4.0% annually from the base period to the future period, which may result in higher rebates; and (2) as WellPoint/Anthem expands, its ability to achieve more favorable contracts or financial arrangements with pharmaceutical manufacturers is enhanced, which may result in higher future rebates. In our view, the resulting rebate credit is a reasonable estimate of our expectation for 2008 rebates applicable to HealthChoice members.

Fourth, as noted previously, Anthem BCBS is incorporating the hearing aid mandate for all ages addressed in the legislation noted above and not phasing in by age over time. Costs estimates are determined using hearing loss incidence estimates and the $1,400 per ear limit contained in the legislation.

Exhibit IX
The financial performance of HealthChoice over the past seven years along with projections for 2007 and 2008 are presented in Exhibit IX. As of this filing Anthem BCBS anticipates pre-tax operating gains of 1.8% of total revenue for 2007. The loss ratio projected for 2008 is 87.4%.

Based on the assumptions in this filing, Anthem BCBS anticipates that the loss ratio in 2007 will be 87.6% (including the savings offset payment in claims for the calculation of the loss ratio).

Exhibit X
Presented in Exhibit X are historical distributions of enrollment by benefit option along with the rates of change in those distributions.

Exhibit XI
The calculation of the commission component of the required premiums is presented in Exhibit XI. A number of factors impact the level of commission in rates including the level of new sales, the portion of

sales produced by the broker community, the average period that a subscriber maintains continuous coverage, the amount of commission paid per subscriber, and the length of time commission is paid. Currently Anthem BCBS is paying $15.20 PCPM for the first twenty four months of a contract. In an effort to maintain the incentives to sell and increase the HealthChoice membership, Anthem BCBS intends to increase this amount to $15.75 in January of 2008.

Exhibit XII

HealthChoice experience since inception is presented in Exhibit XII. Experience is presented for Mandated, Non-Mandated, and all benefits combined. Actual experience through 2006 is included along with projections for 2007 and 2008.

Exhibit XIII

The determination of the impact of the expansion of dependent coverage through age 25 is presented in Exhibit XIII.

Exhibit XIV

Preventive Care and Supplemental Care Accident Rider Derivation

Anthem BCBS has also utilized the rating methodology for the Preventive Care and Supplemental Accident Rider that was reviewed and approved by the Bureau of Insurance. The benefits of the optional preventive care and supplemental accident amendment are two-fold:

1. The preventive care portion of the amendment removes the application of the deductible from a list of preventive care services.
2. The supplemental accident portion of the amendment pays up to $500 for treatment of an accidental injury.

The methodology used was to analyze 2006 claim experience for those members with the rider and determine the total value of claims that Anthem BCBS paid due to the presence of the rider that would otherwise have accumulated to the member's deductible. These claims were then converted to a per member per month basis, trended forward to the rating period, adjusted for premium tax, pre-tax profit and risk, investment income, and the savings offset payment, and converted to a contract basis.

Claim experience on the rider led to a decrease of 14.9% in proposed rates included in this filing.

Exhibit XV

Community rate increases by benefit option and contract type are presented within Exhibit XV.

Attachment A

Included in this attachment are the HealthChoice Non-Mandated proposed rates.

Attachment B

Included in this attachment are the HealthChoice Mandated proposed rates.

Attachment C
Attachment C presents the rating factors for the mandated mental health optional amendment for HealthChoice contracts. This amendment is priced by applying a rate factor to the base premium for the primary policy. These factors have not been increased from the factors currently approved and in use.

Attachment D
Included in Attachment D is the letter and accompanying utilization factors based on benefit differences as provided by Milliman USA and currently in use and approved for HealthChoice rates.